TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
James Weiss, MD

Respondent Name
Mitsui Sumitomo Insurance Company of America

MFDR Tracking Number
M4-15-1839-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 19, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to MSIG on December 8, 2014, this request was in response to no payment of the $798.48 for the EMG/NCV Designated Doctor Referred performed on March 20, 2014. We received a payment of $543.83. We are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: $254.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 27, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2014	Evaluation & Management, new patient (99203) EMG/NCV (95886, 95910, & A4556)	$254.65	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   From Explanation of Benefits dated December 17, 2014:
   - 29 – The time limit for filing has expired.
   - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

   From Explanation of Benefits dated January 21, 2015:

   For CPT Code 99203:
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - T13 – Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 11 months from the date of service.
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 5211 – Nurse audit has resulted in an adjusted reimbursement.
   - 5213 – Services are not payable as documentation does not support the services rendered.

   For CPT Codes 95886 and 95910:
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

   For CPT Code A4556:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment for CPT Code 99203 supported?
2. Are the insurance carrier's reasons for denial or reduction of payment for CPT Code A4556 supported?
3. What is the correct Maximum Allowable Reimbursement (MAR) for the payable disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed CPT Code 99203 with claim adjustment reason code 5213 – "Services are not payable as documentation does not support the services rendered." 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient.

   The American Medical Association (AMA) CPT code description for 99203 is:

   > Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: **A detailed history; A detailed examination; Medical decision making of low**

complexity [emphasis added]. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

The 1995 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Detailed History:
    - "An *extended* [History of Present Illness (HPI)] consists of four or more elements of the HPI." Documentation found five elements of HPI were reviewed, thus meeting the requirements for an extended HPI.
    - "An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems." Documentation found five systems were reviewed. This meets the requirements for an extended ROS.
    - A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. Documentation finds a review of the past medical history, which meets the requirements for a pertinent PFSH.

  The Guidelines state, "To qualify for a given type of history all three elements in the table must be met." A review of the submitted documentation indicates that all elements were met for this component of CPT Code 99203.
- Documentation of the Detailed Examination:
    - A "*detailed* [examination should include] an extended examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)." A review of the submitted documentation finds that a limited examination was performed for two body areas. Therefore, this component of CPT Code 99203 was not met.
- Documentation of Decision Making of Low Complexity:
    - *Number of diagnoses or treatment options* – Review of the submitted documentation finds that a new diagnosis to the examiner was presented, with no additional workup planned, exceeding the documentation requirements of low complexity.
    - *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor reviewed a radiology test. This does not meet the requirements for low complexity.
    - *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include one acute uncomplicated injury, which presents a low level of risk. "The highest level of risk in any one category…determines the overall risk." The documentation supports that this element met the criteria for low risk.

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**." A review of the submitted documentation supports that this component of CPT Code 99203 was met.

Because only two of the required three components of CPT Code 99203 were met, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended for this code.

2. The insurance carrier denied disputed CPT Code A4556 with claim adjustment reason code 243 – "The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed." Medicare lists this code as bundled, which is defined as follows: "Payment for covered services are always bundled into payment for other services not specified." Therefore, the insurance carrier's denial of this code is supported. Additional reimbursement cannot be recommended for this code.
3. Procedure code 95886, service date March 20, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice

expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.86. The practice expense (PE) RVU of 1.67 multiplied by the PE GPCI of 0.916 is 1.52972. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.816 is 0.03264. The sum of 2.42236 is multiplied by the Division conversion factor of $55.75 for a MAR of $135.05 at 2 units is $270.10.

Procedure code 95910, service date March 20, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2 multiplied by the geographic practice cost index (GPCI) for work of 1 is 2. The practice expense (PE) RVU of 3.07 multiplied by the PE GPCI of 0.916 is 2.81212. The malpractice RVU of 0.12 multiplied by the malpractice GPCI of 0.816 is 0.09792. The sum of 4.91004 is multiplied by the Division conversion factor of $55.75 for a MAR of $273.73.

4. The total allowable for the disputed services is $543.83. The insurance carrier paid $543.83. Therefore no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	May 15, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.